FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030551

Facility Name: BRIGHTVIEW CARE CENTER, INC.

Address: 4538 N. BEACON (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: 773-275-7200 **Fax #** 773-275-7543

IDPA ID Number: 36-3408520

Date of Initial License for Current Owners: 2/1/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) CARY DRAZNER C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,338	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,338	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,252	2,380	2,902	35,534	8
9	SNF/PED					9
10	ICF	12,545			12,545	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,797	2,380	2,902	48,079	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.86%

D. How many bed-hold days during this year were paid by Public Aid?
1,290 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 2,300

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	153,091	34,529	10,938	198,558		198,558		198,558			1
2	Food Purchase		233,409		233,409	(13,817)	219,593	(115)	219,478			2
3	Housekeeping	151,703	61,657		213,360		213,360	677	214,037			3
4	Laundry	69,301	26,727		96,028		96,028		96,028			4
5	Heat and Other Utilities			99,165	99,165		99,165	2,304	101,469			5
6	Maintenance	51,543	22,888	49,377	123,808		123,808	(1,488)	122,320			6
7	Other (specify):*							28	28			7
8	**TOTAL General Services**	425,638	379,210	159,480	964,328	(13,817)	950,512	1,406	951,918			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,472,571	128,652	25,640	1,626,863		1,626,863	(449)	1,626,414			10
10a	Therapy	122,290		10,723	133,013		133,013		133,013			10a
11	Activities	65,695	19,839	2,717	88,251		88,251		88,251			11
12	Social Services	76,141		9,346	85,487		85,487		85,487			12
13	Nurse Aide Training											13
14	Program Transportation			250	250		250		250			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,736,697	148,491	53,476	1,938,664		1,938,664	(449)	1,938,215			16
	C. General Administration											
17	Administrative	208,551		12,000	220,551		220,551	52,596	273,147			17
18	Directors Fees											18
19	Professional Services			301,093	301,093	(21,075)	280,018	(202,719)	77,299			19
20	Dues, Fees, Subscriptions & Promotions			43,743	43,743		43,743	(12,714)	31,029			20
21	Clerical & General Office Expenses	105,760	53,304	169,027	328,091		328,091	(65,633)	262,458			21
22	Employee Benefits & Payroll Taxes			333,962	333,962	13,817	347,779		347,779			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,845	2,845		2,845	1,360	4,205			24
25	Other Admin. Staff Transportation			1,639	1,639		1,639	140	1,779			25
26	Insurance-Prop.Liab.Malpractice			87,861	87,861		87,861	793	88,654			26
27	Other (specify):*							25,641	25,641			27
28	**TOTAL General Administration**	314,311	53,304	952,170	1,319,785	(7,259)	1,312,527	(200,536)	1,111,991			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,476,646	581,005	1,165,126	4,222,777	(21,075)	4,201,702	(199,579)	4,002,123			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

BRIGHTVIEW CARE CENTER, INC.
0030551
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	13,817	
2	FOOD		13,817

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	21,075	
19	PROFESSIONAL FEES		21,075

To reclass cost of appealing real estate taxes

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. #0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			46,333	46,333		46,333	61,314	107,647			30
31	Amortization of Pre-Op. & Org.							4,277	4,277			31
32	Interest			70,599	70,599		70,599	129,366	199,965			32
33	Real Estate Taxes					21,075	21,075	148,241	169,316			33
34	Rent-Facility & Grounds			411,792	411,792		411,792	(411,792)				34
35	Rent-Equipment & Vehicles			7,357	7,357		7,357	792	8,149			35
36	Other (specify):*											36
37	**TOTAL Ownership**			536,081	536,081	21,075	557,156	(67,802)	489,354			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,647	70,408	146,055		146,055		146,055			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,508	78,508		78,508		78,508			42
43	Other (specify):*	98,306		6,900	105,206		105,206	(105,206)				43
44	**TOTAL Special Cost Centers**	98,306	75,647	155,816	329,769		329,769	(105,206)	224,563			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,574,952	656,652	1,857,023	5,088,627		5,088,627	(372,587)	4,716,040			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(53,125)	30		9
10	Interest and Other Investment Income	(134)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(115)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(375)	21		18
19	Entertainment				19
20	Contributions	(4,830)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(130,965)	21		24
25	Fund Raising, Advertising and Promotional	(7,902)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(124,138)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (321,584)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(51,003)	VARIOUS	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (51,003)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (372,587)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

STATE OF ILLINOIS

BRIGHTVIEW CARE CENTER, INC.

ID# 0030551

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	PROFESSIONAL FEES	(6,250)	19	2
3	BANK TRUST FEES	(450)	21	3
4	THEFT & LOSS	(7,026)	21	4
5	MARKETING SALARY	(98,306)	43	5
6	MISCELLANEOUS INCOME	(15)	21	6
7	COPE (POLITICAL EDUCATION) DUES	(231)	20	7
8	CAPITALIZED R&M	(4,810)	6	8
9	MARKETING CONSULTANT	(6,900)	43	9
10	NON-ALLOWABLE SEMINAR (MARKETING)	(75)	24	10
11	NON-ALLOWABLE SEMINAR (OUT-OF-STATE)	(75)	24	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(124,138)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(115)											(115)	2
3	Housekeeping				677								677	3
4	Laundry													4
5	Heat and Other Utilities				1,092	1,212							2,304	5
6	Maintenance	(4,810)			2,447	875							(1,488)	6
7	Other (specify):*					28							28	7
8	**TOTAL General Services**	(4,925)			4,216	2,115							1,406	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(449)								(449)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**				(449)								(449)	16
	C. General Administration													
17	Administrative			5,167	46,525	904							52,596	17
18	Directors Fees													18
19	Professional Services	(6,250)		388	(196,980)	123							(202,719)	19
20	Fees, Subscriptions & Promotions	(12,963)		4	236	9							(12,714)	20
21	Clerical & General Office Expenses	(138,831)	450	7	72,648	93							(65,633)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(150)			1,510								1,360	24
25	Other Admin. Staff Transportation				140								140	25
26	Insurance-Prop.Liab.Malpractice				684	109							793	26
27	Other (specify):*			1,055	24,586								25,641	27
28	**TOTAL General Administration**	(158,194)	450	6,621	(50,651)	1,238							(200,536)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(163,119)	450	6,621	(46,884)	3,353							(199,579)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(53,125)	106,632	16	6,525	1,266							61,314	30
31	Amortization of Pre-Op. & Org.		4,277										4,277	31
32	Interest	(134)	126,998		92	2,410							129,366	32
33	Real Estate Taxes		146,143			2,098							148,241	33
34	Rent-Facility & Grounds		(411,792)		9,032	(9,032)							(411,792)	34
35	Rent-Equipment & Vehicles				792								792	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(53,259)	(27,742)	16	16,441	(3,258)							(67,802)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(105,206)											(105,206)	43
44	**TOTAL Special Cost Centers**	(105,206)											(105,206)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(321,584)	(27,292)	6,637	(30,443)	95							(372,587)	45

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				BRIGHTVIEW BUILDING CO		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 265,392	BRIGHTVIEW BUILDING CO	100.00%	$	$ (265,392)	1
2	V	34	RENTAL INCOME - RE TAX	146,400	BRIGHTVIEW BUILDING CO	100.00%		(146,400)	2
3	V	32	INTEREST INCOME	1,860	BRIGHTVIEW BUILDING CO	100.00%		(1,860)	3
4	V	32	MORTGAGE INTEREST		BRIGHTVIEW BUILDING CO	100.00%	128,858	128,858	4
5	V	31	AMORTIZATION		BRIGHTVIEW BUILDING CO	100.00%	4,277	4,277	5
6	V	30	DEPRECIATION		BRIGHTVIEW BUILDING CO	100.00%	106,632	106,632	6
7	V	33	REAL ESTATE TAX		BRIGHTVIEW BUILDING CO	100.00%	146,143	146,143	7
8	V	21	BANK TRUST FEES		BRIGHTVIEW BUILDING CO	100.00%	450	450	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 413,652			$ 386,360	$ * (27,292)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 17,167	$ 17,167	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	388	388	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	4	4	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	7	7	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,055	1,055	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	16	16	20
21	V								21
22	V	17	MANAGEMENT FEES	12,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(12,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,000			$ 18,637	$ * 6,637	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 677	$ 677	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,092	1,092	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	2,447	2,447	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	(449)	(449)	18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	48,640	48,640	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	360	360	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	236	236	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	72,648	72,648	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	1,510	1,510	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	140	140	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	684	684	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	24,586	24,586	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	6,525	6,525	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	92	92	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	9,032	9,032	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	792	792	30
31	V	19	HOME OFFICE	197,340	MANAGCARE, INC.	100.00%	0	(197,340)	31
32	V	17	ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	(731)	(731)	32
33	V	17	ADMIN. SALARY - AHUVA WEINREB		MANAGCARE, INC.	100.00%	(801)	(801)	33
34	V	17	ADMIN. SALARY - JOSHUA DAVIS		MANAGCARE, INC.	100.00%	(583)	(583)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 197,340			$ 166,897	$ * (30,443)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 1,212	$ 1,212	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		875	875	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		28	28	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		904	904	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		123	123	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		9	9	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		93	93	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		109	109	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		1,266	1,266	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		2,410	2,410	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		2,098	2,098	25
26	V	34	RENT	9,032	MAZEL MANAGEMENT		0	(9,032)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,032			$ 9,127	$ * 95	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	YOSEF DAVIS	Owner	Administrative	72.34%	SEE ATTACHED	10	16.67%	SALARY	$ 15,577	17-1	1
2	YOSEF DAVIS							Intercare	17,167	17-7	2
3	MOSHE DAVIS	Dir of Operations	Administrative		SEE ATTACHED	8.4	21.00%	SALARY	26,692	17-1	3
4	MOSHE DAVIS							Managcare	(724)	17-7	4
5	JOSHUA DAVIS	Relative	Administrative		SEE ATTACHED	6.6	16.50%	SALARY	21,500	17-1	5
6	AHUVA WEINREB	Administrator	Administrative		SEE ATTACHED	5	25.00%	SALARY	13,462	17-1	6
7	AHUVA WEINREB							Managcare	(2,928)	17-7	7
8	MOSHE WOLF	Owner	Administrative	2.13%	SEE ATTACHED	11	19.64%	Managcare	13,369	17-7	8
9	MOSHE WOLF							Mazel	904	17-7	9
10	STANLEY KLEM	Owner	Administrative	2.13%	SEE ATTACHED	8	20.00%	Managcare	20,960	17-7	10
11	SHOSHANA BRAUN	Relative	Clerical		SEE ATTACHED	2.8	20.14%	Alloc Sal	1,685	21-7	11
12											12
13								TOTAL	$ 127,664		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	6	$ 103,000	$ 103,000	10	$ 17,167	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	2,330		10	388	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	25		10	4	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	44		10	7	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	6,328		10	1,055	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	95		10	16	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 111,822	$ 103,000		$ 18,637	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOKEEPING INC.	996,360	4	$ 3,420	$	197,340	$ 677	1
2	5	UTILITIES	BOOKEEPING INC.	996,360	4	5,512		197,340	1,092	2
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	996,360	4	12,353		197,340	2,447	3
4	10	NURSING SALARIES	BOOKEEPING INC.	996,360	4	(2,266)	(2,266)	197,340	(449)	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	996,360	4	245,581	245,581	197,340	48,640	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	996,360	4	1,820		197,340	360	6
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	996,360	4	1,190		197,340	236	7
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	996,360	4	366,796	292,203	197,340	72,648	8
9	24	SEMINARS	BOOKEEPING INC.	996,360	4	7,624		197,340	1,510	9
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	996,360	4	708		197,340	140	10
11	26	INSURANCE	BOOKEEPING INC.	996,360	4	3,452		197,340	684	11
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	996,360	4	124,135		197,340	24,586	12
13	30	DEPRECIATION	BOOKEEPING INC.	996,360	4	32,945		197,340	6,525	13
14	32	INTEREST EXPENSE	BOOKEEPING INC.	996,360	4	464		197,340	92	14
15	34	RENT - BUILDING (RELATED)	BOOKEEPING INC.	996,360	4	45,600		197,340	9,032	15
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	996,360	4	4,000		197,340	792	16
17										17
18	17	ADMIN. SALARY - MOSHE DA	AVG HRS WORKED	40	4	(3,475)	(3,475)	8	(731)	18
19	17	ADMIN. SALARY - AHUVA WE	AVG HRS WORKED	20	4	(3,205)	(3,205)	5	(801)	19
20	17	ADMIN. SALARY - JOSHUA DA	AVG HRS WORKED	40	4	(3,537)	(3,537)	7	(583)	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 843,117	$ 525,301		$ 166,897	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG. INC.	996,360	4	$ 6,120	$	197,340	$ 1,212	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. INC.	996,360	4	4,420	1,820	197,340	875	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. BOOKPNG. INC.	996,360	4	139		197,340	28	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC.	996,360	4	4,562		197,340	904	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. INC.	996,360	4	620		197,340	123	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC.	996,360	4	44		197,340	9	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. INC.	996,360	4	470		197,340	93	7
8	26	INSURANCE	MNGCR. BOOKPNG. INC.	996,360	4	549		197,340	109	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. INC.	996,360	4	6,392		197,340	1,266	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. INC.	996,360	4	12,167		197,340	2,410	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. INC.	996,360	4	10,593		197,340	2,098	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 46,076	$ 1,820		$ 9,127	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MANUFACTURER'S BANK		X	LINE OF CREDIT			$	$ 255,000			$ 30,499	1
2	MANUFACTURER'S BANK		X	AUTO	$339.46	1/7/2000	17,000	13,628	12/7/04	7.25%	1,011	2
3	MID-NORTH FINANCIAL		X	MORTGAGE	$35,116.00			1,152,083		10.50%	128,858	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,455.46		$ 17,000	$ 1,420,711			$ 160,368	9
	B. Non-Facility Related*											
10	Supplemental Schedule										508	10
11	MID-AMERICA	X									39,089	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 39,597	14
15	TOTALS (line 9+line14)						$ 17,000	$ 1,420,711			$ 199,965	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME						$	$			$ (134)	1
2	INTEREST INCOME-BLDG CO										(1,860)	2
3	ALLOC - MANAGCARE	X									92	3
4	ALLOC - MAZEL MGMT	X									2,410	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 508	21

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	150,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	148,241	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,759)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	150,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	21,075	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 24,611 For 19 94-96 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	169,316	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	145,629	8
	1996	149,212	9
	1997	144,564	10
	1998	147,131	11
	1999	146,143	12

2000 ACCRUAL = 1999 EXPENSES + 2%
$146,143 X 102% = 150,000 (ROUNDED)
REFUND NOT OFFSET SINCE IT IS NOT FOR REAL ESTATE TAX USED FOR REIMBURSEMENT
RE TAX ALLOCATED FROM MAZEL MANAGEMENT - $2098

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 64,152
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 4,277
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY-BRIGHTVIEW BLDG CO.			$ 73,992	1
2					2
3	TOTALS			$ 73,992	3

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143		1986		$ 1,899,326	$ 106,632	35	$ 54,266	$ (52,366)	$ 1,433,495	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	10,306	536	20	543	7	7,938	9
10	Various			1987	4,719	150	20	236	86	3,188	10
11	Various			1988	2,895	92	20	145	53	1,860	11
12	Various			1989	67,265	2,012	20	3,272	1,260	39,777	12
13	Various			1991	22,384		20	1,120	1,120	8,148	13
14	Various			1992	17,019	143	20	143		12,666	14
15	Various			1993	44,200	983	20	2,211	1,228	16,446	15
16	Various			1994	63,594	2,525	20	3,181	656	20,755	16
17	Various			1995	7,105	305	20	356	51	1,986	17
18	ELEVATOR IMPROVEMENT			1996	23,900	613	20	1,195	582	5,975	18
19	GAS/DRYER VENTING			1996	2,157	55	20	108	53	459	19
20	ALARM SYSTEM			1996	1,329	34	20	66	32	281	20
21	CCTV SYSTEM			1996	3,631	93	20	182	89	774	21
22	NURSES CALL SYSTEM			1996	888	23	20	44	21	187	22
23	IMPRV CIRCUIT PANELS			1996	4,335	111	20	217	106	1,013	23
24											24
25	PAGE 12-1 REP TOTALS				51,306	2,696		2,228	(468)	30,547	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				11,918	878		344	(534)	1,924	33
34	PAGE 12B TOTALS				252,407	5,320		11,637	6,317	17,792	34
35	PAGE 12A TOTALS				67,654	2,097		3,388	1,291	8,762	35
36	TOTAL (lines 4 thru 35)				$ 2,558,338	$ 125,298		$ 84,882	$ (40,416)	$ 1,613,973	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BATHROOM IMPROVEMENT			1996			20				9
10	FIRE PUMP			1996	1,400	36	20	70	34	350	10
11	WALL COVER			1997	5,536		20	277	277	854	11
12	PAINTING			1997	11,875		20	594	594	1,832	12
13	PAINT			1998	497		20	25	25	71	13
14	LIGHT FIXTURES			1998			20				14
15	CCTV SYSTEM			1998	3,552		20	178	178	415	15
16	WINDOW TREATMENTS			1998	3,556	407	20	178	(229)	356	16
17	3RD NURSING STATION			1998	3,250	568	20	163	(405)	326	17
18	PAINT			1998	997		20	50	50	146	18
19	REPAIR GENERATOR			1998	850		20	43	43	90	19
20	2ND NURSING STATION			1998	3,250	568	20	163	(405)	326	20
21	BALLAST			1998	6,890		20	345	345	690	21
22	WALLPAPER			1998	623		20	31	31	83	22
23	SCREENS			1998	655		20	33	33	83	23
24	PAINT			1998	662		20	33	33	85	24
25	ELEVATOR REPAIR			1998	1,600		20	80	80	187	25
26	PAINTING			1998			20				26
27	CARPET			1998	890		20	45	45	116	27
28	ALARM SYSTEM			1998	4,331	111	20	217	106	470	28
29	PAINT			1998	700		20	35	35	105	29
30	COOLING TOWER			1998	700		20	35	35	82	30
31	SPRINKLERS			1998	1,370	35	20	69	34	150	31
32	PAINTING			1998	3,500	90	20	175	85	525	32
33	COOLING TOWER			1998	2,175	56	20	109	53	254	33
34	VARIOUS IMPR			1998	5,645	145	20	282	137	705	34
35	WATER LINE			1998	3,150	81	20	158	77	461	35
36	TOTAL (lines 4 thru 35)				$ 67,654	$ 2,097		$ 3,388	$ 1,291	$ 8,762	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CCTV SYSTEM			1998			20				9
10	ELEVATOR FRAME			1998	1,007		20	50	50	146	10
11	FIRE EQUIPMENT			1999	2,162	55	20	108	53	216	11
12	CONSTRUCTION CONSULT			1999	2,980	76	20	149	73	236	12
13	LIFE SAFETY CONSULT			1999	930	24	20	47	23	74	13
14	DAMPERS & GRILLS			1999	19,323	495	20	966	471	1,530	14
15	FIREDOOR MASONRY			1999	4,200	108	20	210	102	280	15
16	ELEVATOR			1999	4,600	118	20	230	112	364	16
17	ASPHALT REPAIRS			1999	4,015		20	201	201	285	17
18	WINDOWS			1999	58,097	1,490	20	2,905	1,415	4,600	18
19	CCTV SYSTEM			1999	4,391		20	220	220	238	19
20	TELEPHONE SYSTEM			1999	730		20	37	37	40	20
21	GENERATOR			1999	100,000	2,564	20	5,000	2,436	7,917	21
22	INTERCOM			1999	557		20	28	28	37	22
23	BOILER REPAIR			1999	2,500		20	125	125	229	23
24	TUCKPOINTING			1999	1,350		20	68	68	113	24
25	ALARM SYSTEM			1999	1,583		20	79	79	145	25
26	ELECTRIC DOOR			1999	836		20	42	42	56	26
27	EXHAUST FANS			1999	3,230		20	162	162	176	27
28	EMERGENCY SYSTEM			1999	4,000	103	20	200	97	300	28
29	EMERGENCY GENERATOR			2000	18,892	262	20	551	289	551	29
30	KICKPLATES FOR DOORS			2000	559		20	7	7	7	30
31	SHAFT BEARING			2000	2,344	18	20	39	21	39	31
32											32
33	ELECTRIC CONNECTIONS			2000	6,326	7	20	26	19	26	33
34	COMPUTER CABLE RUN			2000	4,903		20	102	102	102	34
35	TELEPHONE LINES			2000	2,892		20	85	85	85	35
36	TOTAL (lines 4 thru 35)				$ 252,407	$ 5,320		$ 11,637	$ 6,317	$ 17,792	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VIDEO MONITORING SYS			2000	3,615		20	181	181	181	9
10	RAMP RAILING EXTNSN			2000	1,000		20	29	29	29	10
11	SHAFT BEARING			2000	4,307	862	20	54	(808)	54	11
12	COMM/ACS PROCESSOR			2000	1,346		20	45	45	45	12
13	BOILER			2000	1,650	16	20	35	19	1,615	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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24											24
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,918	$ 878		$ 344	$ (534)	$ 1,924	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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16											16
17											17
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1985	Alloc-Mazel	$ 20,434	$ 1,063	30	$ 681	$ (382)	$ 10,387	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION FROM MANAGCARE			1997	2,382	298	20	238	(60)	814	9
10	ALLOCATION FROM MANAGCARE			1993	187	10	20	9	(1)	71	10
11	ALLOCATION FROM MANAGCARE			1988	292	9	20	14	5	179	11
12	ALLOCATION FROM MANAGCARE			1986	22,098	1,129	8,20	1,012	(117)	16,367	12
13	ALLOCATION FROM MAZEL MANAGEMENT			2000	217	1	20	3	2	3	13
14	ALLOCATION FROM MAZEL MANAGEMENT			1998	764	26	20	38	12	103	14
15	ALLOCATION FROM MAZEL MANAGEMENT			1997	713	18	20	36	18	119	15
16	ALLOCATION FROM MAZEL MANAGEMENT			1996	486	11	20	24	13	111	16
17	ALLOCATION FROM MAZEL MANAGEMENT			1995	110	3	20	5	2	31	17
18	ALLOCATION FROM MAZEL MANAGEMENT			1994	434	8	20	22	14	118	18
19	ALLOCATION FROM MAZEL MANAGEMENT			1993	256	7	20	13	6	95	19
20	ALLOCATION FROM MAZEL MANAGEMENT			1991	192	6	20	9	3	84	20
21	ALLOCATION FROM MAZEL MANAGEMENT			1990	298	6	20	15	9	155	21
22	ALLOCATION FROM MAZEL MANAGEMENT			1989	187	4	20,25	8	4	90	22
23	ALLOCATION FROM MAZEL MANAGEMENT			1987	424	8	10,15	11	3	406	23
24	ALLOCATION FROM MAZEL MANAGEMENT			1986	1,713	89	15,20	90	1	1,295	24
25	ALLOCATION FROM MAZEL MANAGEMENT			1985	119		10			119	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 51,306	$ 2,696		$ 2,228	$ (468)	$ 30,547	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 193,270	$ 17,432	$ 16,584	$ (848)		$ 94,215	37
38	Current Year Purchases	46,554	10,534	2,705	(7,829)		2,705	38
39	Fully Depreciated Assets	174,862	1,576	455	(1,121)		174,862	39
40								40
41	TOTALS	$ 414,686	$ 29,542	$ 19,744	$ (9,798)		$ 271,782	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	2000 TOYOTA CAMRY	1999	$ 20,600	$ 5,000	$ 2,060	$ (2,940)	10	$ 2,403	42
43		Alloc from Managcare		8,979	930	959	29	5	5,639	43
44										44
45										45
46	TOTALS			$ 29,579	$ 5,930	$ 3,019	$ (2,911)		$ 8,042	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,076,595	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 160,770	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 107,645	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (53,125)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,893,797	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

BRIGHTVIEW CARE CENTER, INC.
0030551
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
BRIGHTVIEW CARE CENTER	172,730	14,000	14,366	366	85,901
BRIGHTVIEW BUILDING PARTNERSHIP					
MAZEL MANAGEMENT	96	15	10	(5)	36
MANAGCARE	20,444	3,417	2,208	(1,209)	8,278
INTER CARE LTD.					
TOTALS	193,270	17,432	16,584	(848)	94,215

LINE 29: CURRENT YEAR

BRIGHTVIEW CARE CENTER	45,822	9,802	2,655	(7,147)	2,655
BRIGHTVIEW BUILDING PARTNERSHIP					
MAZEL MANAGEMENT					
MANAGCARE	732	732	50	(682)	50
INTER CARE LTD.					
TOTALS	46,554	10,534	2,705	(7,829)	2,705

LINE 30: FULLY DEPRECIATED

BRIGHTVIEW CARE CENTER	64,782	1,560		(1,560)	64,782
BRIGHTVIEW BUILDING PARTNERSHIP	80,000				80,000
MAZEL MANAGEMENT	167				167
MANAGCARE	27,350		445	445	27,350
INTER CARE LTD.	2,563	16	10	(6)	2,563
TOTALS	174,862	1,576	455	(1,121)	174,862

TOTALS (Should Tie to Totals on Page 13)

BRIGHTVIEW CARE CENTER	283,334	25,362	17,021	(8,341)	153,338
BRIGHTVIEW BUILDING PARTNERSHIP	80,000				80,000
MAZEL MANAGEMENT	263	15	10	(5)	203
MANAGCARE	48,526	4,149	2,703	(1,446)	35,678
INTER CARE LTD.	2,563	16	10	(6)	2,563
TOTALS	414,686	29,542	19,744	(9,798)	271,782

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,357 Description: BEDS
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Managcare		$	$ 792	17
18					18
19					19
20					20
21	TOTAL		$	$ 792	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 32,582	$		$ 32,582	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,263			2,263	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			35,563			35,563	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				57,124		57,124	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2					148		148	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					18,374		18,374	13
14	TOTAL			$		$ 70,408	$ 75,646		$ 146,054	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	LAB	3,654
2	NURSING SUPPLIES	6,840
3	EQUIPMENT RENTAL	6,576
4	RADIOLOGY	1,304
5		
6		
7		
8		
9		
10		
		18,374

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,381	$ 9,381	1
2	Cash-Patient Deposits	51,795	51,795	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,355,615	1,355,615	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,163	96,163	6
7	Other Prepaid Expenses	37,553	37,553	7
8	Accounts Receivable (owners or related parties)	50,485	50,485	8
9	Other(specify): See supplemental schedule	3,147	64,615	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,604,139	$ 1,665,607	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,026,000	14
15	Leasehold Improvements, at Historical Cos	396,935	396,935	15
16	Equipment, at Historical Cost	437,115	517,115	16
17	Accumulated Depreciation (book methods)	(349,442)	(2,020,035)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		64,152	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(39,919)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 484,608	$ 1,094,248	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,088,747	$ 2,759,855	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 812,071	$ 812,071	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,772	46,772	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,531	144,531	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,514	10,514	31
32	Accrued Real Estate Taxes(Sch.IX-B)		150,000	32
33	Accrued Interest Payable	202	11,477	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,427	3,427	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	582,907	582,907	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,600,424	$ 1,761,699	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	268,627	268,627	39
40	Mortgage Payable		1,152,083	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 268,627	$ 1,420,710	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,869,051	$ 3,182,409	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 219,696	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,088,747	$ #REF!	48

*(See instructions.)

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. **#** 0030551 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
EMPLOYEE ADVANCES	3,147	3,147
REAL ESTATE TAX ESCROW		60,801
NOTE RECEIVABLE-YOSEF DAVIS		667
	3,147	64,615

OTHER CURRENT LIABILITIES:	Amount	Amount
OTHER CURRENT LIABILITIES	16,319	16,319
DUE TO MID AMERICA	563,350	563,350
DUE TO MANAGCARE	3,238	3,238
	582,907	582,907

OTHER NON CURRENT ASSETS:

Construction In Progress

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 30,335	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 30,335	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	219,361	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(30,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 189,361	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 219,696	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	BRIGHTVIEW CARE CENTER, INC. #	0030551	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		30,335
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		30,335
Equity(Deficit) from Page 17 Col 1		219,696
Related Party		
Equity(Deficit)	-669542	
Income	27292	
		(642,250)
Combined Equity - End of Year		(422,554)

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,078,529	1
2	Discounts and Allowances for all Levels	(224,816)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,853,713	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	181,686	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 181,686	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,961	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,379	19
20	Radiology and X-Ray	1,867	20
21	Other Medical Services	32,814	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 93,021	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	134	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 134	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	179,434	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 179,434	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,307,988	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	964,328	31
32	Health Care	1,938,664	32
33	General Administration	1,319,785	33
	B. Capital Expense		
34	Ownership	536,081	34
	C. Ancillary Expense		
35	Special Cost Centers	251,261	35
36	Provider Participation Fee	78,508	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,088,627	40
41	**Income before Income Taxes (line 30 minus line 40)****	219,361	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 219,361	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIGHTVIEW CARE CENTER, IN # 0030551 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	VENDING COMMISSIONS	533
2	MISCELLANOUS INCOME (ADJUSTED PAGE 5)	15
3	BAD DEBT RECOVERY	150,426
4	OFFICERS LIFE INSURANCE	3,094
5	REAL ESTATE TAX REFUND	24,326
6	STATE REPLACEMENT TAX CREDIT	1,040
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	179,434

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,776	1,941	$ 52,806	$ 27.21	1
2	Assistant Director of Nursing	1,335	1,408	30,824	21.89	2
3	Registered Nurses	21,203	22,799	428,944	18.81	3
4	Licensed Practical Nurses	24,115	26,973	437,179	16.21	4
5	Nurse Aides & Orderlies	56,774	61,031	488,485	8.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,418	10,077	122,290	12.14	8
9	Activity Director	1,507	1,571	14,323	9.12	9
10	Activity Assistants	6,423	6,695	51,372	7.67	10
11	Social Service Workers	4,862	5,357	76,141	14.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,395	20,641	153,091	7.42	15
16	Dishwashers					16
17	Maintenance Workers	4,631	4,980	51,543	10.35	17
18	Housekeepers	20,362	22,585	151,703	6.72	18
19	Laundry	9,804	10,390	69,301	6.67	19
20	Administrator	2,032	2,095	55,910	26.69	20
21	Assistant Administrator	2,227	2,560	48,830	19.07	21
22	Other Administrative	4,736	4,736	103,810	21.92	22
23	Office Manager					23
24	Clerical	9,745	10,320	105,760	10.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,131	3,479	34,333	9.87	31
32	Other Health Care(specify)					32
33	Other(specify)	2,472	2,696	98,306	36.46	33
34	TOTAL (lines 1 - 33)	205,948	222,334	$ 2,574,951 *	$ 11.58	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 8,400	1-3	35
36	Medical Director	MONTHLY	4,800	9-3	36
37	Medical Records Consultant	MONTHLY	4,032	10-3	37
38	Nurse Consultant	584	20,362	10-3	38
39	Pharmacist Consultant	MONTHLY	1,200	10-3	39
40	Physical Therapy Consultant	74	3,700	10A-3	40
41	Occupational Therapy Consultant	91	4,533	10A-3	41
42	Respiratory Therapy Consultant	56	2,240	10A-3	42
43	Speech Therapy Consultant	5	250	10A-3	43
44	Activity Consultant	54	2,717	11-3	44
45	Social Service Consultant	174	9,345	12-3	45
46	Other(specify)				46
47	PURCHASING CONSULTANT	MONTHLY	2,538	1-3	47
48	OUTSIDE NURSING SERVICES		45	10-3	48
49	TOTAL (lines 35 - 48)	1,038	$ 64,162		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MARKETING	2,472	2,696	$ 98,306	$ 36.46
	2,472	2,696	$ 98,306	$ 36.46

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ELIMELECH TROPPER (1/00-12/00)	Administrator	0	$ 51,964
YOSEF MEYSTEL (1/00)	Administrator	0	3,946
RALPH RICANA (8/00-12/00)	Asst Admin	0	20,703
DESIREE MAURER (3/00-12/00)	Asst Admin	0	28,127
SEE ATTACHED	Other Admin		103,810
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 208,550

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - INTER CARE LTD.	$ 12,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 12,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
MANAGCARE, INC	BOOKKEEPING	197,340
ACHIEVE ACCREDITATION	JCAHO CONSULTING	2,560
PERSONNEL PLANNERS	UNEMPLOYMNT TAX CONS	1,270
ACHIEVE ACCREDITATION	ADMIN CONSULTANT	4,076
SEE ATTACHED	LEGAL	17,575
FR&R	ACCOUNTING	48,483
COMMITMENT CONSULTING	A/R CONSULT	26,288
URBAN REAL ESTATE RESRCH	APPRAISAL FEE	3,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 301,092

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,342
Unemployment Compensation Insurance	20,251
FICA Taxes	193,161
Employee Health Insurance	59,732
Employee Meals	13,817
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	3,980
CHRISTMAS EXPENSE	2,635
EMPLOYEE PENSION	11,465
EMPLOYEE BENEFITS	10,275
EMPLOYEE DISABILITY INSURANCE	3,120
TOTAL (agree to Schedule V, line 22, col.8)	$ 347,778

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,735
Health Care Worker Background Check	
(Indicate # of checks performed 166)	1,165
PROMOTIONAL ADVERTISING	7,902
LICENSE, PERMITS, & FEES	2,559
DUES & SUBSCRIPTIONS	5,321
Allocation from related parties	248
Less: Public Relations Expense	( )
Non-allowable advertising	(7,902)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,028

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,695
ALLOCATION FROM MANAGCARE	1,510
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,205

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIGHTVIEW CARE CENTER, INC. # 0030551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCL ON LT CARE - $4,967**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,700** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **78,507**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **13,817** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw